



# CHILDREN'S WAIVER PROGRAM



## TECHNICAL ASSISTANCE MANUAL

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Revised Edition - May 2004

# APPENDICES

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\* These items will be forthcoming.



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## CHILDREN'S WAIVER COMMUNITY LIVING SUPPORT SERVICES APPENDIX

### **SECTION 1 - CHILDREN WITH CHALLENGING BEHAVIORS**

#### **1.1 PURPOSE**

This Section is to help the CMSHP determine whether the challenging behavioral needs of the child support hourly care and other support services, and to determine the appropriate range of hourly care that can be authorized under the Community Living Support (CLS) waiver service. The following categories do not, in and of themselves, establish eligibility for publicly funded hourly care.

The amount of CLS services (i.e. the number of hours) that can be authorized for a child is based on several factors, including the child's care needs which establish waiver eligibility, child's and family's circumstances, and other resources for daily care (e.g. private health insurance, trusts bequests, private pay). In addition to identifying the family situation and the specific behaviors as described in the category definitions, the following elements contribute to the overall assessment of need:

- Type of behaviors identified;
- Frequency, intensity, and duration of identified behaviors;
- How recently serious behaviors occurred;
- Actual specific effects of the behavior on persons in family and property;
- Level of family intervention required to prevent behavioral episodes;
- Extent to which family must alter normal routine to address behavioral needs of the child;
- Prognosis for change in the child's behavior;
- Whether or not child functions more effectively in any current setting than in other settings; and
- Age, size, and mobility of child.



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## 1.2 CATEGORIES OF CARE

### 1.2.A. CATEGORY IV

<b>Qualifications</b>	Demonstrates mild level behaviors that may interfere with the daily routine of the family.
<b>Definitions</b>	<b>Mild Behavior:</b> Infrequent or intermittent behaviors including pinching, hitting, slapping, kicking, head banging, and/or elopement without careful supervision when there is evidence of lack of judgment regarding danger, or an extremely high activity level requiring extensive supervision and redirection.

### 1.2.B. CATEGORY III

<b>Qualifications</b>	Demonstrates a daily pattern of medium level behaviors including self-injurious, physically aggressive or assaultive behaviors that have not resulted in hospitalization or emergency room treatment for injuries in the past year, or has engaged in occasional, significant property destruction that is not life-threatening.
<b>Definitions</b>	<b>Pattern of Behavior:</b> In addition to a single serious episode in the last year, significant daily behaviors are documented.  <b>Medium Behavior:</b> Includes behaviors defined in the Category II definition of "moderate behavior" when emergency room treatment or hospitalization have not been required for treatment of injuries resulting from the behavior. Examples include head banging, resulting in bleeding and bruising without concussion or detached retina, hair pulling without removing hair from the scalp, smearing feces without PICA, and biting without drawing blood.  <b>Occasional Property Destruction:</b> Property destruction that occurs with a frequency not greater than one time per week.

### 1.2.C. CATEGORY II

<b>Qualifications</b>	Demonstrates a daily pattern of moderate self-injurious, physically aggressive or assaultive behavior when medical intervention, or emergency room treatment has been required for treatment of injuries in the past year without resulting hospitalization, or if the child has engaged in frequent, significant property destruction that is not life-threatening.
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<b>Definitions</b>	<b>Moderate Behavior:</b> Includes behaviors that pose a significant risk of injury to self or others in the immediate environment. Examples include physical assault or self-abuse resulting in injuries requiring hospital emergency room treatment without hospital admission in the past year, biting that breaks the skin, hair pulling resulting in removal of clumps of hair from the scalp, multiple daily episodes of smearing feces with associated PICA, and head banging resulting in documented concussion or detached retina.
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## 1.2.D CATEGORY I

<b>Qualifications</b>	Demonstrates a pattern of severe self-injurious, physically aggressive or assaultive behavior, or life-threatening property destruction that has occurred one or more times in the past year. Documented evidence of additional behavioral problems on a frequent basis each day supports a need for one-to-one intensive behavioral treatment.
<b>Definitions</b>	<b>Severe Behavior:</b> Poses a very significant risk of serious injury or death to self, a family member, or others in the immediate environment. Examples include fire setting, physical assault or self-abuse resulting in injuries to self or others requiring inpatient hospital admission for treatment in the past year.



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## **SECTION 2 – MEDICALLY AND PHYSICALLY COMPLEX CHILDREN**

### **2.1 PURPOSE**

The purpose of this Section is to help the CMHSP determine whether CLS services are medically necessary. The following categories do not, in and of themselves, establish eligibility for publicly funded hourly care.

#### **2.1.A. CATEGORY IV**

<b>Qualifications</b>	A medical condition and requires significant levels of daily assistance or guidance with activities of daily living (ADLs). In addition, medical condition is stable and observations and interventions are required infrequently. Interventions require minimal training and are associated with minimal or no risk to health status.
<b>Examples</b>	<p>Includes levels of support that would exceed those expected for a person of the child's age in the areas of:</p> <ul style="list-style-type: none"><li>▪ Assistance and/or guidance in ADLs including eating, toileting, bathing, grooming, dressing, and mobility (ambulation and transferring);</li><li>▪ Assistance and/or guidance with physical transfer (e.g. bed to chair);</li><li>▪ Assistance and/or guidance with therapeutic positioning and physical therapy; or</li><li>▪ The child weighs 80 pounds or more and is not ambulatory and/or not mobile and unable to assist the primary caregiver.</li></ul>

#### **2.1.B. CATEGORY III**

<b>Qualifications</b>	A medical condition that routinely requires daily hourly care or support in order to maintain and/or improve health status. Clinical observations and interventions may be intermittent. Medical interventions are typically associated with minimal risk to health status and delayed interventions are not associated with imminent risk to health status.
<b>Examples</b>	<p>Includes a combination of interventions such as:</p> <ul style="list-style-type: none"><li>▪ G-tube feedings with no oral suctioning needs;</li><li>▪ PRN oxygen administration less often than daily over the past 30 days with or without pulse oximeter;</li><li>▪ Daily oxygen administration at less than two liters without pulse oximeter and without the need for on-going judgments and observations for oxygen needs (e.g. routine nightly administration without other skilled nursing interventions);</li><li>▪ Catheterization fewer than five times per day;</li></ul>



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- |  |   |
|--|---|
|  | <ul style="list-style-type: none"><li>▪ Routine chest physiotherapy four or more times per day;</li><li>▪ Ostomy care;</li><li>▪ Total feeding or formal feeding program requiring more than 45 minutes per meal with need for special trunk-head positioning;</li><li>▪ Concurrent diagnosis of severe hypertonicity, severe contractures, or severe scoliosis that requires therapeutic positioning every two hours; or</li><li>▪ Documented evidence that positioning causes apnea and cyanosis and that positioning is limited to positions with the body in less than a 45 degree angle to horizontal plane.</li></ul> |
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## 2.1.C. CATEGORY II AND CATEGORY I

Services for Category II and I children are covered under the Medicaid State Plan private duty nursing (PDN) benefit. Refer to the Private Duty Nursing Chapter of this manual for PDN coverage criteria.



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## **SECTION 3 – COVERAGE DECISIONS**

### **3.1 DECISION RESPONSIBILITY**

The MDCH Children's Waiver Review Team will continue to review all plans of service and current assessments, and prior authorize waiver services, for those children who:

- Qualify for Category of Care I ; or
- Any child who has been approved to receive additional CLS hours under the exception process.

The responsible CMHSP, following the Children's Waiver Decision Guide in the following subsection, will review and prior authorize waiver services for those Children's Waiver beneficiaries who are:

- Determined to qualify for Categories II, III, or IV.

### **3.2 DECISION GUIDE**

The determination of the amount of hourly care should result from a person-centered planning/family centered practice process that considers both the child's and family's needs. The Decision Guide Table below assists in identifying the range of hours provided for children based on their category of care and the family's resources to provide that care. It is expected that hourly care services will be provided within the range for which the child qualifies. Within the four Categories of Care, are five sections that apply to the child's family status. In determining the total number of hours, it is acceptable to use the highest range within the appropriate section of the eligible category. The range of hours identified in the guide is an average daily amount that is provided seven days a week, based on a monthly total authorization.

**If the child is attending school an average of 25 hours per week, the Section VI maximum would apply unless the maximum exceeds the range qualified for in Section I-V. In that case, the maximum range in Section I-V would apply. The Section VI maximum would not be required during school breaks, such as Christmas, Easter, and summer vacations, or if the child is out of school due to ill ness for 5 or more consecutive days.**





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DECISION GUIDE TABLE				
ADDITIONAL FAMILY RESOURCES	DOCUMENTED CATEGORY OF NEED FOR HOURLY CARE AUTHORIZATION			
	CATEGORY IV	CATEGORY III	CATEGORY II	CATEGORY I
<b>Section I – Number of Caregivers</b> 1. Two or more caregivers live in home; both work F/T 2. Two adult caregivers; one works F/T 3. Two adult caregivers; neither is employed 4. One adult caregiver lives in home and works F/T 5. One adult caregiver; does not work F/T	4 - 8 2 - 8 2 - 4 4 - 8 2 - 6	6 -10 2 - 8 2 - 6 4 -10 2 - 8	8 -12 4 -10 4 - 8 8 -12 8 -10	12 -16 10 -16 8 -12 12 -16 10 -14
<b>Section II – Health Status of Caregivers</b> 1. Significant health issues 2. Some health issues	6 - 8 4 - 6	6 -10 4 - 8	10 -14 8 -12	12 -16 10 -12
<b>Section III – Additional Dependent Children</b> 1. Applicant has one or more siblings age 5 or older 2. Applicant has one or more siblings under age 5	2 - 4 4 - 6	2 - 6 4 - 8	4 - 8 6 - 8	8 -12 8 -12
<b>Section IV – Additional Children with Special Needs</b> 1. Applicant has one or more siblings with nursing needs 2. Applicant has one or more siblings with non-nursing special needs	4 - 8 2 - 4	6 - 8 2 - 6	4 - 8 N/A	8 -12 N/A
<b>Section V – Night Interventions</b> 1. Requires 2 or fewer interventions at night or total time less than one hour 2. Requires 3 or more interventions requiring one hour or more to complete	2 - 4 4 - 8	2 - 6 6 - 8	4 - 8 6 -10	8 -12 8 -12
<b>Section VI – School</b> Child attends school an average of 25 hours per week	6 max	6 max	8 max	12 max



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## 3.3 EXCEPTION PROCESS

The exception process ensures the safety and quality of care of children served by the waiver through consideration of the unique needs of each child and family, and special circumstances that may arise. When occasional relief through respite services is not sufficient, an exception of hourly care may be authorized.

Contingent upon the availability of funds and upon receipt of a Prior Review and Approval Request (PRAR), limited authority to exceed the published hourly care amount defined in the Decision Guide subsection may be granted by the MDCH to a CMHSP to better serve identified children with exceptional care needs. The PRAR must be developed pursuant to family request, person-centered planning/family centered practice team recommendation, and CMHSP administrative concurrence.

The PRAR must document and substantiate both a current clinical (either medical or psychological) necessity for the exception **and** a current lack of natural supports requisite for the provision of the needed level of care. The hourly care services must be essential to the successful implementation of a plan of active treatment as defined by CMS ICF/MR rules, and any enhancements must be essential to maintain the child within their home. Consideration for an exception will be limited to situations outside the family's control that place the child in jeopardy of serious injury or significant deterioration of health status such as:

- A temporary deterioration of the child's clinical condition (e.g. need for nursing care following an acute hospitalization or surgical procedure, or an acute cyclic exacerbation of challenging behaviors);
- A temporary inability of the primary caregivers to provide the requisite level of care (e.g. an acute illness or injury);
- Health condition requires continuous implementation of high risk medically prescribed procedures requiring licensed nursing personnel that are not already addressed within the Decision Guide subsection. The procedures must be beyond the demonstrated capacity of the parents to provide;
- Behavior treatment needs significantly exceed the recommended ranges for the assigned category of care **and** this exception is essential to prevent an otherwise inevitable (i.e. previously documented) deterioration in behavior. The enhanced staffing must be continuously active in the implementation of the behavior treatment plan;
- Natural supports are unable to provide the requisite level of care (e.g. only available care providers have a physical, mental, or emotional disability or they cannot demonstrate competence with the procedures essential to the implementation of the treatment plan). The plan of service must also address plans to rectify the condition or circumstance.

Exceptions may be granted for a specified period not to exceed 180 days. Renewal requests must substantiate the continuing clinical necessity and lack of natural supports.



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Exceptions approved by MDCH can occur in one of the following ways:

- Temporary emergency basis only. Verbal approval can be given to the CMHSP with written justification to be forwarded to MDCH within 10 days; or
- In a nonemergency situation, the CMHSP provides the MDCH with written documentation of the specific rationale to support the exception (i.e. physician's prescription). This would include a revised Plan of Care, highlighting the care needs to be provided with the additional staffing hours, and all current assessments. A response from MDCH will occur within 10 working days.
- When approval of an exception is not granted through either of the two processes listed above, the family, case manager, or MDCH may request a meeting in order to clarify and reconsider the basis for the exception.

MDCH has the option to request a home visit to meet the child when it is necessary for an effective decision.

## 3.4 APPEAL PROCESS

The child and family have the right, under the Michigan Mental Health Code, to appeal a negative coverage decision to the director of the CMHSP. The child and family may also request a recipient's rights investigation through their CMHSP.

The CMS approval of the Children's Waiver requires the availability of a fair hearing for any Medicaid-eligible children enrolled in the Children's Waiver Program, when that child is subject to a negative action. A negative action results when a Medicaid-covered service or benefit is taken away, reduced, or denied to a Medicaid beneficiary. The Medicaid beneficiary must be notified of the negative action in writing. The negative action notice must indicate:

- The beneficiary's right to appeal through the MDCH administrative hearing process;
- The beneficiary has 90 days to submit an appeal; and
- Where to send the appeal.

The MDCH appeal process may occur simultaneously with a recipient's rights or CMHSP administrative appeal process. Individuals and their families are encouraged to resolve disputes regarding waiver services at the local CMHSP level.

The CMHSP is financially responsible for any services that may be approved as a result of the judgment from the administration appeal process.

**MDCH CHILDREN'S WAIVER PROGRAM  
PRIOR REVIEW AND APPROVAL REQUEST  
EXCEPTION HOURS**

**SECTION 1:****NOTE: APPROVAL REFERS TO SERVICE APPROPRIATENESS AND DOES NOT GUARANTEE MEDICAID PAYMENT**

DATE OF REQUEST:			
CHILD'S NAME (Last, First, Middle Initial):	DOB	MEDICAID I.D. NUMBER:	
ADDRESS:	Parent(s) name		
CASE MANAGER'S NAME:	CMHSP:	TELEPHONE NUMBER:	

**SECTION 2:**

DESCRIPTION OF THE CHILD'S CONDITION/FAMILY SITUATION THAT PROMPTED THIS REQUEST (Explain why current hours, respite services, natural and community resources are not sufficient)	Type of Service (nursing/CLS)	Start/End Date	DAILY AMOUNT			
			Current Services	Respite Hours	Enhanced Services	Total

Attach additional narrative justification

Case Manager's Signature \_\_\_\_\_

Date \_\_\_\_\_

DCH USE ONLY

ENROLLED WAIVER PARTICIPANT (ALL REQUIRED RE/CERTIFICATION DOCUMENTATION UP-TO-DATE)

9

Approved as:  Presented 9  Amended 9	Denied (see remarks)  9  No Action Taken  9	Remarks:     _____ Clinical Review Team Chair or Designee	Date _____
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## **PERSON-CENTERED PLANNING REVISED POLICY PRACTICE GUIDELINE**

**October 2002**

### **I. SUMMARY/BACKGROUND**

The Michigan Mental Health Code establishes the right for all individuals to have their Individual Plan of Service developed through a person-centered planning process regardless of age, disability or residential setting. In the past, Medicaid or other regulatory standards have governed the process of plan development. These standards drove the planning process through requirements on the types of assessments to be completed and the professionals to be involved. Person-centered planning departs from this approach in that the individual directs the planning process with a focus on what he/she wants and needs. Professionally trained staff plays a role in the planning and delivery of treatment, and may play a role in the planning and delivery of supports. However, the development of the Individual Plan of Service, including the identification of possible services and professionals, is based upon the expressed needs and desires of the individual. Health and safety needs are addressed in the Individual Plan of Service with supports listed to accommodate those needs.

The Michigan Department of Community Health (MDCH) has advocated and supported a family approach to service delivery for children and their families. This approach recognizes the importance of the family and the fact that supports and services impact the entire family. Therefore, in the case of minors, the child/family is the focus of service planning, and family members are integral to the planning process and its success. The wants and needs of the child/family are considered in the development of the Individual Plan of Service.

Managed care strategies play an important role in planning for, and delivery of, supports, services and/or treatment. Person-centered planning complements these strategies. Both strategies intend to ensure that individuals are provided with the most appropriate services necessary to achieve the desired outcomes. When an individual expresses a choice or preference for a support, service and/or treatment for which an appropriate alternative of lesser cost exists, and compromise fails, a process for dispute resolution and appeal may be needed. This document provides guidelines for addressing disputes.

The literature describes specific methods for person-centered planning, including, but not limited to, individual service design, Personal Futures Planning, MAPS, Essential Lifestyle Planning, Planning Alternative Tomorrows With Hope, etc. This Practice Guideline does not support one model over another. It does, however, define the values, principals and essential elements of the person-centered planning process.

## II. VALUES AND PRINCIPLES UNDERLYING PERSON-CENTERED PLANNING

Person-centered planning is a highly individualized process designed to respond to the expressed needs/desires of the individual.

- A. Each individual has strengths, and the ability to express preferences and to make choices.
- B. The individual's choices and preferences shall always be honored and considered, if not always granted.
- C. Each individual has gifts and contributions to offer to the community, and has the ability to choose how supports, services and/or treatment may help them utilize their gifts and make contributions to community life.
- D. Person-centered planning processes maximize independence, create community connections, and work towards achieving the individual's dreams, goals and desires.
- E. A person's cultural background shall be recognized and valued in the decision-making process.

## III. PCP PRACTICE GUIDELINES

- A. Essential Elements
  - 1. Person-centered planning is a process in which the individual is provided with opportunities to reconvene any or all of the planning processes whenever he/she wants or needs.
  - 2. The process encourages strengthening and developing natural supports by inviting family, friends and allies to participate in the planning meeting(s) to assist the individual with his/her dreams, goals and desires.
  - 3. The development of natural supports shall be viewed as an equal responsibility of the PHP/CMHSP and the individual. The PHP/CMHSP, in partnership with the person, is expected to develop, initiate, strengthen, and maintain community connections and friendships through the person-centered process.
  - 4. The individual is provided with the options of choosing external independent facilitation of his/her meeting(s), unless the individual is receiving short-term outpatient therapy only, medication only, or is incarcerated.
  - 5. Before a person-centered planning meeting is initiated, a pre-planning meeting occurs. In pre-planning the individual chooses:
    - a. dreams, goals, desires and any topics about which he/she would like to talk about
    - b. topics he/she does not want discussed at the meeting
    - c. who to invite

- d. where and when the meeting will be held
  - e. who will facilitate
  - f. who will record
6. All potential support and/or treatment options (array of mental health services including Medicaid-Covered Services and Alternative Services and Mental Health Code-required services) to meet the expressed needs and desires of the individual are identified and discussed with the individual.
- a. Health and safety needs are identified in partnership with the individual. The plan coordinates and integrates services with primary health care.
  - b. The individual is provided with the opportunity to develop a crisis plan.
  - c. Each Individual Plan of Service must contain the date the service is to begin, the specified scope, duration, intensity and who will provide each authorized service.
  - d. Alternative services are discussed.
7. The individual has ongoing opportunities to express his/her needs and desires, preferences, and to make choices. This includes:
- a. Accommodations for communication, with choices and options clearly explained, shall be made.
  - b. To the extent possible, the individual shall be given the opportunity for experiencing the options available prior to making a choice/decision. This is particularly critical for individuals who have limited life experiences in the community with respect to housing, work and other domains.
  - c. Individuals who have court-appointed legal guardians shall participate in person-centered planning and make decisions that are not delegated to the guardian in the Guardianship Letters of Authority.
  - d. Service delivery shall concentrate on the child as a member of a family, with the wants and needs of the child and family integral to the plan developed. Parents and family members of minors shall participate in the person-centered planning process unless:
    - (1) The minor is 14 years of age or older and has requested services without the knowledge or consent of parents, guardian or person in loco parentis within the restrictions stated in the Mental Health Code;
    - (2) The minor is emancipated; or
    - (3) The inclusion of the parent(s) or significant family members would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process as stated in the Mental Health Code. Justification of the exclusion of parents shall be documented in the clinical record.
8. Individuals are provided with ongoing opportunities to provide feedback on how they feel about the service, support and/or treatment they are receiving, and their progress toward attaining valued outcomes. Information is collected and changes are made in response to the individual's feedback.

9. Each individual is provided with a copy of his/her Individual Plan of Service within 15 business days after their meeting.

#### B. Illustrations of Individual Needs

Person-centered planning processes begin when the individual makes a request to the Prepaid Health Plan (PHP)/Community Mental Health Services Program (CMHSP). The first step is to find out from the individual the reason for his/her request for assistance. During this process, individual needs and valued outcomes are identified rather than requests for a specific type of service. Since person-centered planning is an individualized process, how the PHP/CMHSP proceeds will depend upon what the individual requests.

This guideline includes a chart of elements/strategies that can be used by the person representing the PHP/CMHSP, depending upon what the individual wants and needs. Three possible situations are:

1. The individual expresses a need that would be considered urgent or emergent.

When an individual is in an urgent/emergent situation, the goal is to get the individual's crisis situation stabilized. Following stabilization, the individual and PHP/CMHSP will explore further needs for assistance and if required, proceed to a more in-depth planning process as outlined below. It is in this type of situation where an individual's opportunity to make choices may be limited.

2. The individual expresses a need or makes a request for a support, service and/or treatment in a single life domain and/or of a short duration.

A life domain could be any of the following:

- a. Daily activities
- b. Social relationships
- c. Finances
- d. Work
- e. School
- f. Legal and safety
- g. Health
- h. Family relationships, etc.

3. The individual expresses multiple needs that involve multiple life domains for support(s), service(s) or treatment of an extended duration.

The following chart represents the elements/strategies that can be used depending on the kinds of needs expressed by the individual.



<i>ELEMENTS/STRATEGIES</i>	<i>URGENT/ EMERGENT</i>	<i>SHORT DURATION</i>	<i>EXTENDED DURATION</i>
The individual expresses his/her needs and/or desires. Accommodations for communication will be made to maximize his/her ability for expression.	X	X	X
The individual's preferences, choices and abilities are respected.	X	X	X
Potential issues of health and safety are explored and discussed. Supports to address health and safety needs are included in the Individual Plan of Service.	X	X	X
As a result of health or safety concerns or court-ordered treatment, limitations may exist for individual choice. However, opportunities for individuals to express their perceived needs can occur and opportunities to make choices among limited options can be given.	X	X	X
Person-centered planning includes pre-planning activities. These activities result in the determination of whether in-depth treatment or support planning is necessary, and if so, to determine and identify the persons and information that need to be assembled for successful planning to take place.		X	X
In short-term/outpatient service areas, the individual is provided with information on person-centered planning, including pre-planning at or before the initial visit. Individuals are encouraged to invite persons to the session where the plan is developed.		X	

<i>ELEMENTS/STRATEGIES</i>	<i>URGENT/ EMERGENT</i>	<i>SHORT DURATION</i>	<i>EXTENDED DURATION</i>
In collaboration with the PHP/CMHSP, the individual identifies strategies and supports, services and/or treatment needed to achieve desired outcomes.		X	X
<p>Exploration of the potential resources for supports and services to be included in the individual's plan are to be considered in this order:</p> <ul style="list-style-type: none"> <li>The individual.</li> <li>Family, friends, guardian, and significant others.</li> <li>Resources in the neighborhood and community.</li> <li>Publicly-funded supports and services available for all citizens.</li> <li>Publicly-funded supports and services provided under the auspices of the Department of Community Health and Community Mental Health Services Programs.</li> </ul>		X	X
Regular opportunities for individuals to provide feedback are available. Information is collected and changes are made in response to the individual's feedback.		X	X
The individual's support network is explored with that person to determine who can best help him/her plan. The individual and the persons he/she selects together define the individual's desired future, and develop a plan for achieving desired outcomes. For any individual with dementia or other organic impairments, this should include the identification of spouses or other primary care givers who are likely to be involved in treatment or support plan implementation.			X

<i>ELEMENTS/STRATEGIES</i>	<i>URGENT/ EMERGENT</i>	<i>SHORT DURATION</i>	<i>EXTENDED DURATION</i>
The process continues during the planning meeting(s) where the individual and others he/she has selected who know him/her well talk about the desired future and outcomes concentrating on the needs and wants previously identified as needing change.			X

#### IV. ASSURANCES AND INDICATORS OF PERSON-CENTERED PLANNING IMPLEMENTATION

It is the responsibility of the PHP/CMHSP to assure that the Individual Plan of Service is developed utilizing a person-centered planning process. Below are examples of systemic and individual level indicators that would demonstrate that person-centered planning has occurred. The methods of gathering information or evidence may vary, and include the review of administrative documents, clinical policy and guidelines, case record review, satisfaction surveys and interviews/focus groups with individuals and their families.

##### A. Systemic indicators could include, but not be limited to:

1. The PHP/CMHSP has a DCH-approved policy or practice guideline that delineates how person-centered planning will be implemented.
2. Evidence that the PHP/ CMHSP informs individuals of their right to person-centered planning and associated appeal mechanisms, investigates complaints in this area, and documents outcomes.
3. Evidence that the PHP/CMHSP's quality improvement system actively seeks feedback from individuals receiving services, support and/or treatment regarding their satisfaction, providing opportunities to express needs and preferences and the ability to make choices. Information is collected and changes are made in response to the individual's feedback.
4. The PHP/CMHSP's staff development plan includes efforts to ensure that executive team, professional employees, direct care staff, board members, consumers, families and other stakeholders are trained in the philosophy, methods, and implementation activities of person-centered process.
5. The PHP/CMHSP collects information and makes changes when necessary on processes to develop natural supports. Information collected examines the development, initiation, and maintenance of community connections and friendships through the person-centered process.

6. The PHP/CMHSP has developed and implemented, in partnership with individuals with disabilities, a plan for independent facilitation including but not limited to training requirements, performance expectations, satisfaction surveys, retention of skilled facilitators, and ongoing training with support.
- B. Individual indicators could include, but not be limited to:
1. Evidence the individual was provided with information of his/her right to person-centered planning.
  2. Evidence that the individual chose topics he/she would like to talk about in the meeting, topics he/she does not want discussed at the meeting, whether or not other persons should be involved, and those identified were involved in the planning process and in the implementation of the Individual Plan of Service.
  3. Evidence that the individual chose the places and times to meet, convenient to the individual and to the persons he/she wanted present.
  4. Evidence that the individual had choice in the selection of who will facilitate the plan, and treatment or support services provided including staff that will assist in carrying out the activities in the plan.
  5. Evidence that the individual's preferences and choices were considered, or a description of the dispute/appeal process and the resulting outcome.
  6. Evidence that the progress made toward the valued outcomes identified by the individual was reviewed and discussed for the purpose of modifying the strategies and techniques employed to achieve these outcomes.

## **V. DISPUTE RESOLUTION/APPEAL MECHANISMS**

All consumers have the right to a fair and efficient process for resolving complaints regarding their services and supports managed and/or delivered by Prepaid Health Plans (PHPs), their affiliate Community Mental Health Services Programs (CMHSPs) and their provider networks. A recipient of or applicant for public mental health services may access several options to pursue the resolution of complaints. These options are defined through the Recipient Rights requirements referenced in the Michigan Mental Health Code for all recipients of public mental health services, federal law for Medicaid recipients, and the MDCH/PHP or CMHSP contract. It is important to note that an individual receiving mental health services and supports may pursue their complaint within multiple options simultaneously.

Chapters 7, 7a, 4 and 4a of the Mental Health Code describe the broad set of rights and protections for recipients of public mental health services as well as the procedures for the investigation and resolution of recipient rights complaints. Processes for complaints related to the denial, reduction, suspension or termination of services and supports are specified in the Grievance and Appeal Technical Requirement, Attachment 6.3.2.1 of the Department of Community Health Contract for Specialty Services and Supports.

This requirement is based upon the premise that all recipients of, or applicants for, public mental health services will receive notice of their rights and an explanation of the grievance and appeal processes. This requirement in no way requires the exhaustion of grievance or alternative dispute resolution processes prior to the filing of a recipient rights complaint pursuant to Chapter 7 and 7a of the Code.

## VI. DEFINITIONS

**Case Manager/Supports Coordinator** - The staff person who works with the individual to gain access to and coordinate the services, supports and/or treatment that the individual wants or needs.

**Emancipated Minor** - The termination of the rights of the parents to the custody, control, services and earnings of a minor, which occurs by operation of law or pursuant to a petition filed by a minor with the probate court.

**Emergency Situation** - A situation when the individual can reasonably be expected, in the near future, to physically injure himself, herself, or another person; is unable to attend to food, clothing, shelter or basic physical activities that may lead to future harm, or the individual's judgment is impaired leading to the inability to understand the need for treatment resulting in physical harm to self or others.

**Family Member** - A parent, stepparent, spouse, sibling, child, or grandparent of a primary consumer, or an individual upon whom a primary consumer is dependent for at least 50 percent of his or her financial support.

**Guardian** - A person appointed by the court to exercise specific powers over an individual who is a minor, legally incapacitated, or has developmental disabilities.

**Individual Plan of Service** - A written Individualized Plan of Service directed by the individual as required by the Mental Health Code. This may be referred to as a treatment plan or a support plan.

**Minor** - An individual under the age of 18 years.

**Natural Support** - A person who is involved in an individual's life other than just for pay.

**Person-Centered Planning** - A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and honor the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

**Urgent Situation** - A situation in which an individual is determined to be at risk of experiencing an emergency situation in the near future if he or she does not receive care, treatment or support services.

## VII. LEGAL REFERENCES

Mental Health Code Act, 258 MI. §§ 409-1-7 (1974 & Supp. 1996).

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- Refer to the Technical Requirement



## Child/Family Centered Plan

<b>CUSTOMER:</b>	<b>SS#:</b>	<b>DOB:</b>
<b>PERSON RESPONSIBLE FOR TREATMENT COORDINATION:</b>		

**LOCATION of Planning Session:** \_\_\_\_\_ **DATE of Planning Session:** \_\_\_\_\_

**START TIME:** \_\_\_\_\_ **STOP TIME:** \_\_\_\_\_

**CUSTOMER CHOSE LOCATION AND TIME:** Yes      No

Individuals participating in the development of the plan: *(list family members, significant others, community supports, service providers as appropriate)*

Name	Relationship
------	--------------

**Child/Family or Natural Supports available to achieve Needs/Wants & Dreams/Desires:** *(list available informal resources and identify which goals they will be used to achieve)*

**Identify and address barriers to Dreams & Desires or community life:**

*( Explain how, where and when these occur; identify supports and accommodations needed to overcome barriers)*

Name:

DOB:

Case Number:

**Are there Health/Safety Concerns with the expressed preferences/choices the Child/Family has made?**

*(discuss these in detail and discuss plan to provide education or information)*

**Needs that will be deferred:** *(dreams or goals which will not be a part of this plan, however, they may be addressed later, or simply not possible in this intervention; identify referrals to other community supports )*

**Goals requiring other Professional Supports:** *(list any goals to be completed with any other professional,, discipline involved, target completion dates)*

**Criteria for discharge:** *(How will we know when we are done with this intervention)*

<b>Customer:</b>	<b>Case #:</b>	<b>Date of Treatment Goal:</b>
<b>Date(s) of Planned Periodic Review:</b>		<b>Clinician:</b>

**Child/Family Centered Plan of Service**  
**Treatment/Service Goal**

<b>Dream/Desire:</b> <i>(quote from child/family)</i>
<b>Strength:</b> <i>(what the child/family is good at which will help them accomplish their goal)</i>
<b>Goal: # _____</b> <i>(as defined by provider/family)</i>

Steps to Reach Goal (Objectives)	Resources/People Who Will Help (who, what, Intensity, frequency (how often))	Duration	Outcome

This goal is documented by:			Date:
Name	Title	Agency	
This goal is monitored by:			Frequency:
Name	Title	Agency	

*\*Please refer to the back of this page for periodic updates on the above goal.*

Name:

DOB:

Case Number:

**Periodic Review #1** (Describe how the child/family feels about progress made towards and how effective the supports/services/treatment has been, include quotes from child/family, indicate whether goal and objectives are to be continued, amended or discontinued)

**Date of Update:**

**Progress Noted:** ☐ yes ☐ no

**Status:**

**Customer Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signature/Credentials:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Periodic Review #2** (Describe how the child/family feels about progress made towards and how effective the supports/services/treatment has been, include quotes from child/family, indicate whether goal and objectives are to be continued, amended or discontinued).

**Date of Update:**

**Progress Noted:** ☐ yes ☐ no

**Status:**

Customer Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature/Credentials: \_\_\_\_\_

Date: \_\_\_\_\_

Name:

DOB:

Case Number:

## Signatures of Plan Developers

**My signature** indicates that my family and/or I helped develop this child/family centered plan and agree to be responsible for carrying out the stated goals. I have been provided the information regarding the grievance/appeal process and understand I may contact the Recipient Rights office at CMHSP if I have any concerns regarding my treatment.

\_\_\_\_\_  
Identified Customer\_\_\_\_\_  
Date\_\_\_\_\_  
Parent/Legal guardian\_\_\_\_\_  
Date\_\_\_\_\_  
Parent/Legal guardian\_\_\_\_\_  
Date\_\_\_\_\_  
Participant\_\_\_\_\_  
Date\_\_\_\_\_  
Participant\_\_\_\_\_  
Date\_\_\_\_\_  
Participant\_\_\_\_\_  
DateA copy **MUST** be provided within 15 days of the planning meeting to:

\_\_\_\_ Customer Date Provided \_\_\_\_\_

\_\_\_\_ Guardian Date Provided \_\_\_\_\_

\_\_\_\_ Other Date Provided \_\_\_\_\_

Customer Declined/Date \_\_\_\_\_

**My signature** indicates that I assisted the child/family in the development of this plan and agree to provide services to guide the customer and his/her family in the achievement of their goals.

\_\_\_\_\_  
Clinical Service Provider/credentials\_\_\_\_\_  
Date\_\_\_\_\_  
Other/credentials\_\_\_\_\_  
Date

**My signature** indicates I concur that the services outlined in the plan are clinically and medically appropriate and necessary.

\_\_\_\_\_  
Physician's Signature/credentials\_\_\_\_\_  
Date

## ADEQUATE NOTICE OF ACTION (SAMPLE FORM)

**ADEQUATE ACTION NOTICE**

Date  
Name  
Address  
City, State, Zip

RE: Beneficiary's Name:  
Beneficiary's Medicaid ID Number:

Dear \_\_\_\_\_:

Following a review of the mental health services for which you have applied, it has been determined that the following service(s) shall not be authorized. The reason for this action is <reason> . The legal basis for this decision is 42 CFR 440.230(d).

Service(s)	Effective Date
_____	_____
_____	_____

If you do not agree with this action, you may request a Michigan Department of Community Health fair hearing within 90 calendar days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person.

To request a fair hearing, complete the "Request for Hearing" form, and return it in the enclosed pre-addressed envelope, or mail to:

ADMINISTRATIVE TRIBUNAL  
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
P.O. BOX 30195  
LANSING, MI 48909-7695

You have a right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call, toll-free, 877-833-0870.

You may contact the Administrative Tribunal, toll free, at 877-833-0870 if you have further questions.

Enclosures:  
Hearing Request Form  
Return Envelope

<Address>  
<City, State, Zip>  
<phone number – voice>  
<phone number – fax>

You have the right to an expedited local appeal if waiting for the standard time for a local appeal would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, you must call your CMHSP.

You may request both a fair hearing and a local appeal. The fair hearing and local appeal processes may occur at the same time. You may contact the Administrative Tribunal, toll free, at 877-833-0870 or the CMHSP if you have further questions.

Sincerely,

Enclosures:

Hearing Request Form  
Return Envelope

ADVANCE NOTICE OF ACTION (SAMPLE FORM)

**ADVANCE ACTION NOTICE**

**Date**

Name  
Address  
City, State, Zip

RE: Beneficiary's Name:  
Beneficiary's Medicaid ID Number:

Dear \_\_\_\_\_:

Following a review of mental health services and supports that you are currently receiving, it has been determined that the following service(s) shall be <reduced, terminated or suspended> effective <date>. The reason for this action is <reason>. The legal basis for this decision is 42 CFR 440.230(d).

**Service(s)**

**Effective Date**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

If you do not agree with this action, you may request a Michigan Department of Community Health fair hearing within 90 calendar days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person.

To request a fair hearing, complete the enclosed "Request for Hearing" form, and return it in the enclosed pre-addressed envelope, or mail to:

**ADMINISTRATIVE TRIBUNAL  
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
P.O. BOX 30195  
LANSING, MICHIGAN 48909-7695**

You have a right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call, toll-free, 877-833-0870.



If you continue to receive benefits because you requested a fair hearing you may be required to repay the benefits. This may occur if:

- The proposed termination or denial of benefits is upheld in the hearing decision
- You withdraw your hearing request
- You or the person you asked to represent you does not attend the hearing

If you do not agree with this action, you may also request a local appeal, either orally or in writing, with your CMHSP within 45 calendar days of the date of this notice by contacting:

**<name of CMHSP office/individual responsible for local appeal process>**

**<Address>**

**<City, State, Zip>**

**<phone number – voice>**

**<phone number – fax>**

You have the right to an expedited local appeal if waiting for the standard time for a local appeal would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, you must call your CMHSP.

You may request both a fair hearing and a local appeal. The fair hearing and local appeal processes may occur at the same time. You may contact the Administrative Tribunal, toll free, at 877-833-0870 or the CMHSP if you have further questions.

Sincerely,

Enclosures:

Hearing Request Form  
Return Envelope

# REQUEST for an ADMINISTRATIVE HEARING

## INSTRUCTIONS

Michigan Department of Community Health

Use this form to request an administrative hearing. An administrative hearing is an impartial review of a decision made by the Michigan Department of Community Health (or one of its contracted agencies) that the appellant (beneficiary, resident, patient, consumer, or responsible party) believes is inappropriate.

### AUTHORIZED HEARING REPRESENTATIVE:

You may choose to have another person represent you at a hearing.

- This person can be anyone you choose.
- This person may request a hearing for you.
- This person may also represent you at the hearing.
- You **MUST** give this person written permission to represent you. You may provide a letter or a copy of a court order naming this person as your guardian or conservator.
- You **DO NOT** need any written permission if this person is your spouse or attorney.

### GENERAL INSTRUCTIONS:

- Read **ALL** Instructions **FIRST**, then remove this instruction sheet before completing the form.
- Complete **Sections 1 and 2 ONLY**. Do **NOT** complete Section 3.
- Please use a **PEN** and **PRINT FIRMLY**.
- Remove the **BOTTOM (Pink)** copy and save with the Instruction Sheet for your records.
- If you have any questions, please call toll free **1 ( 877 ) 833 - 0870**.
- After you complete this form, mail it in the enclosed postage paid envelope to:

**ADMINISTRATIVE TRIBUNAL  
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
PO BOX 30195  
LANSING MI 48909**

### IMPORTANT:

- After the Administrative Tribunal receives your request for a hearing, your hearing will be scheduled and a notice will be mailed to you and/or your representative within **30 days**.

**Authority:** MCL 330.114; MCL 333.5451; MCL 400.9; Executive Order No. 1996-1; Executive Order No. 1996-4; 42 CFR 431.200; 7CFR 246.18; MAC R 325.910, *et seq.*; MAC R 330.4011; MAC R 330.5011; MAC R 330.8005, *et seq.*; MAC R 400.3401, *et seq.*; and relevant Interagency Agreements.

**Completion:** Is Voluntary, but if NOT completed, a hearing will **not** take place.

- The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.
- If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to the Department of Community Health.

If you do not understand this, call the Department of Community Health.  
Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria.

إذا لم تفهم هذا، اتصل بإدارة الصحة المحلية التابعة لولاية ميتشيجن.

**1 ( 877 ) 833 - 0870**

## REQUEST FOR AN ADMINISTRATIVE HEARING

Michigan Department of Community Health

### IMPORTANT:

- Read the instruction sheet first.
- See the instruction sheet for **non-discrimination** and **PA 431** information.

### ADMINISTRATIVE TRIBUNAL

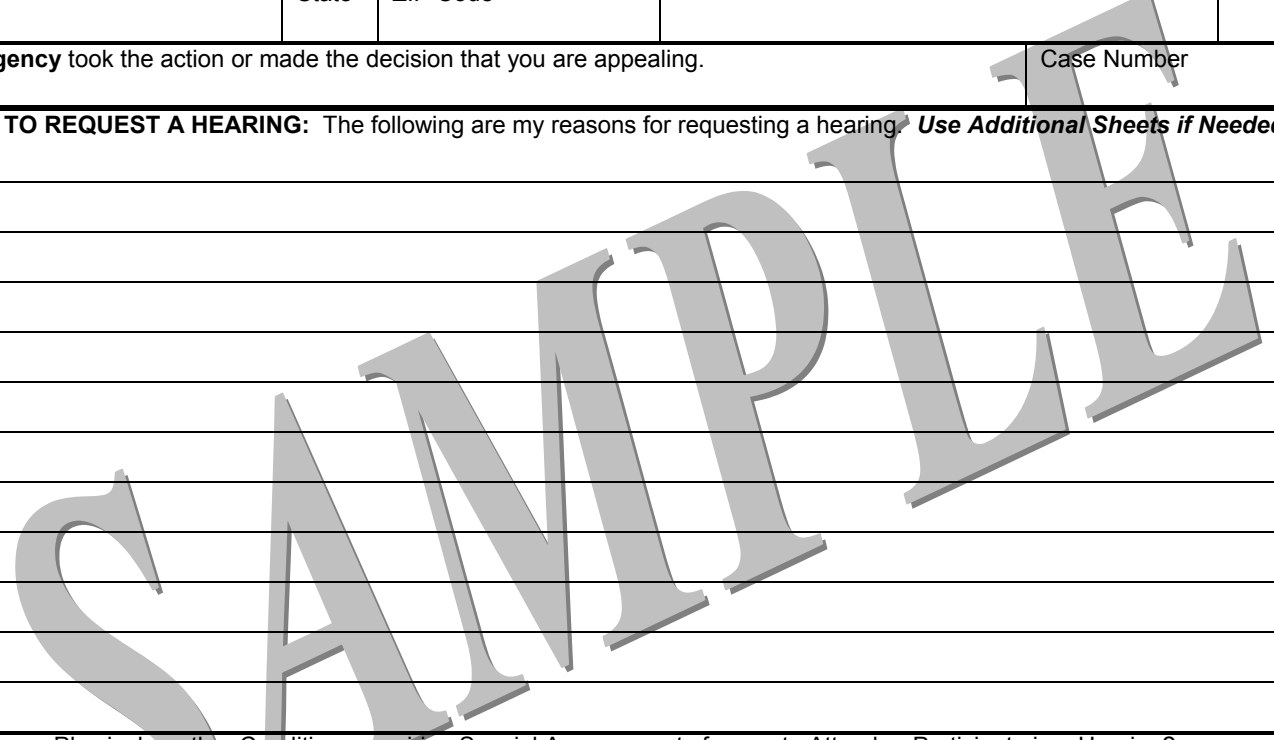
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

PO BOX 30195

LANSING MI 48909

1 (877) 833-0870

### SECTION 1 – To be completed by PERSON REQUESTING A HEARING:

Your Name			Your Telephone Number (      )		Your Social Security Number	
Your Address (No. & Street, Apt. No., etc.)			Your Signature			Date Signed
City	State	ZIP Code				
What <b>Agency</b> took the action or made the decision that you are appealing.					Case Number	
<b>I WANT TO REQUEST A HEARING:</b> The following are my reasons for requesting a hearing. <i>Use Additional Sheets if Needed.</i>						
						
Do you have Physical or other Conditions requiring Special Arrangements for you to Attend or Participate in a Hearing?						
<input type="checkbox"/> <b>NO</b>						
<input type="checkbox"/> <b>YES</b> (Please Explain in <b>Here</b> ):						

### SECTION 2 – Authorized Hearing Representative Information:

*Read the information near the top of the Instruction Sheet FIRST*

Has Someone Agreed to Represent you at a Hearing?						
<input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>YES</b> (If Yes, complete the information below)						
Name of Representative			Representative Telephone Number (      )			
Address (No. & Street, Apt. No., etc.)			Representative Signature			Date Signed
City	State	ZIP Code				

### SECTION 3 – To be completed by the AGENCY distributing this form to the appellant:

Name of Agency			AGENCY Contact Person Name			
AGENCY Address (No. & Street, Apt. No., etc.)			AGENCY Telephone Number (      )			
City	State	ZIP Code	State Program or Service being provided to this appellant			

# ADMINISTRATIVE TRIBUNAL FORMS REQUISITION

Michigan Department of Community Health

- Refer to this number for inquiries.



**AT -**

- For questions about this requisition call **(517) 335-8360**

## INSTRUCTIONS:

- Order only the forms listed below on this requisition. All other items will be deleted.
- Specify the quantity you **NEED** in single units (use **EACH**, not pad, package, box, carton, etc.).
- Retain the PINK copy for your records.
- Leave Shaded Areas BLANK.

- Allow **3 weeks** for processing.
- Complete this form and mail it to:

**FORMS DISTRIBUTION  
MDCH ADMINISTRATIVE SERVICES  
3423 N ML KING SUITE 124  
PO Box 30195  
LANSING MI 48909-7695**

## REQUESTER INFORMATION:

Requesting Business or Office Name			Date of Request	Phone Number ( )
Attention of			Approval Signature(s) (as needed)	
Delivery Address (Number and Street)				
City	State	ZIP Code		

## REQUESTED ITEMS:

1 COMMODITY NUMBER  <b>4829 -</b>	2 QUANTITY NEEDED <b>EACH</b> (NOT Pad, Pkg, Box or Ctn.)	3 FORM or ENVELOPE IDENTIFICATION NUMBER	4 FORM or ENVELOPE TITLE
<b>0092</b>		DCH-0092	Request For An Administrative Hearing
<b>0093</b>		DCH-0093	Hearing Request Withdrawal
<b>0367</b>		DCH-0367	Hearing Summary
<b>0368</b>		DCH-0368	Administrative Tribunal – Business Reply Envelope
<b>0646</b>		DCH-0646	Administrative Tribunal Forms Requisition

AUTHORITY: None  
COMPLETION: Is Voluntary, but this information is required to obtain a supply of the above printed materials.

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs, or disability.

## For Office Use Only

Administrative Services Approval	Date Processed	DMB - Processed by
----------------------------------	----------------	--------------------

DCH-0646 (8-99)

# HEARING SUMMARY

Michigan Department of Community Health

**INSTRUCTIONS:**

- Complete this form and mail it to the following address within **10 days** of receipt of the hearing request.
- If you have questions, you may call toll free **1 (877) 833-0870**

- **ADMINISTRATIVE TRIBUNAL  
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
PO BOX 30195  
LANSING MI 48909**

**SECTION 1 – Case Information:**

Case Name	Case Number	Co.	Dist.	Sect.	Unit	Wkr.
-----------	-------------	-----	-------	-------	------	------

**SECTION 2 – Hearing Summary:**

1. Effective Date of Action	2. Date Appellant was Notified of Department Action	3. Date Hearing Requested
4. Deleted Pending Hearing? <input type="checkbox"/> NO <input type="checkbox"/> YES		5. Was Conference Held Prior to Hearing? <input type="checkbox"/> NO <input type="checkbox"/> YES
6. Explanation of Action(s) Taken:		
7. Facts and Fact Sources Used in Taking This Action(s):		
8. Law(s), Regulation(s) or Policy Manual Item(s) Used in Taking This Action(s):		

**SECTION 3 – Signature:**

9. Prepared By: (Signature)	10. Date Signed	11. Phone Number
The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs, or disability.		<b>AUTHORITY:</b> 42 CFR 431.200 – 431.250 <b>COMPLETION:</b> Is Voluntary <b>CONSEQUENCE:</b> None

DCH-0367 (W) (8-99) Previous Edition Obsolete

**HEARING REQUEST WITHDRAWAL**

Michigan Department of Community Health

*The purpose of this form is for an appellant to **withdraw** his / her request for an administrative hearing.***APPELLANT INSTRUCTIONS:**

- Answer ALL questions completely.
- Please use a PEN and PRINT FIRMLY.
- Remove the BOTTOM copy for your records.
- If you have any questions, please call the Hearing Helpline at: **1 (877) 833 - 0870**.

- After you complete this form, mail it in the enclosed postage paid envelope to:

**ADMINISTRATIVE TRIBUNAL**  
**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**  
**PO BOX 30195**  
**LANSING MI 48909**

Your Name			Your Telephone Number (      )		Your Case or File Number	
Your Address (No. & Street, Apt. No., etc.)			Your Signature		Date Signed	
City	State	ZIP Code				
Docket Number.			Date of Scheduled Hearing		Your Social Security Number	

**I DO NOT WANT A HEARING:** Please CANCEL my request for a hearing for the following reason:
☐ **The Department of Community Health has changed its action/decision.**
☐ **Other (Please explain):**

<b>Authority:</b> 42 CFR 431.200 - 431.250 <b>Completion:</b> Is Voluntary, but if NOT completed, a hearing WILL take place	The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to the Department of Community Health.
If you do not understand this, call the Department of Community Health. Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria. إذا لم تفهم هذا، اتصل بإدارة الصحة المحلية التابعة لولاية ميتشيجان.	
<b>1 ( 877 ) 833 - 0870</b>	